DEPARTMENT OF THE ARMY
U.S. ARMY HUMAN RESOURCES COMMAND
1 RESERVE WAY
ST. LOUIS, MO 63132-5200

AHRC-PLS-I

5 MAR 2004

MEMORANDUM FOR ASSIGNED DRILLING INDIVIDUAL MOBILIZATION AUGMENTATION (DIMA) AND ARMY RESERVE ELEMENT (ARE) SOLDIERS

SUBJECT: Memorandum of Instruction for Submitting Pay Related Documents for Inactive Duty Training (IDT) Periods Performed by DIMA and ARE Program Participants

1. Welcome to the DIMA or ARE Program. This memorandum provides financial information pertaining to the IDT periods (drills) you will be performing.

2. The enclosed U.S. Army Human Resources Command (HRC) assignment or amended assignment order containing the statement "AUTH FOR DRILLING IMA PRGM. PAY CAT B," or "ASSIGNED TO JOINT RESERVE UNIT. AUTHORIZED TO PERFORM IDT FOR PAY. PAY CAT A" authorizes you to begin scheduling and performing the specified number of drills in a fiscal year with your assigned agency.

3. These drills are for pay as well as retirement points. An IDT period equals four hours of training. You cannot exceed two IDTs for pay in a 24-hour period. If you exceed the maximum drills authorized, the excess will be converted to retirement points.

4. You will receive points only for IDTs performed before the effective date on your DIMA or ARE authorization order. The DIMA and ARE Program pays only base pay (no travel or per diem) for IDTs.

5. You must complete the enclosed forms listed in a through i below for accessioning into Defense Joint Military Pay System-Reserve Components (DJMS-RC).

a. SF 1199A (Direct Deposit Sign-Up Form): Direct deposit is mandatory. Submit an SF 1199A completed by your financial institution. You may attach a voided blank check to the SF 1199A instead of completing the SF 1199A.

b. W-4 Form (Employee's Withholding Allowance Certificate): The W4 is necessary even though you may have a current form on file with your employer.

c. DD Form 2058 (State of Legal Residence Certificate): The DD Form 2058 is used for tax purposes.

d. DD Form 2058-1 (State Income Tax Exemption Test Certificate): The DD Form 2058-1 is used for exemption from State income tax.

e. DD Form 2058-2 (Native American State Income Tax Withholding Exemption Certificate): The DD Form 2058-2 is used for Native American service members to stop State income tax withholdings.

f. DD Form 93 (Record of Emergency Data): The DD Form 93 must have the original signature of the Soldier, the appropriate witness, and date.

g. SGLV Form 8286 (Servicemen's Group Life Insurance (SGLI) Election and Certificate) and SGLV Form 8286A (Family Coverage Election): Choose the amount of SGLI you desire for yourself on the SGLV Form 8286 (using $10,000 increments) from a minimum of $10,000 to $250,000 maximum coverage. SGLI coverage is automatically $250,000 unless you decline coverage or elect a lesser amount. If desired, complete the SGLV Form 8286A for family coverage.

h. Termination Statement for Servicemen's Group Life Insurance: If you currently have SGLI coverage under other than a DIMA or ARE status, termination is required in order to avoid duplicate billing. The signed statement will terminate other SGLI coverage.

i. AHRC Form 4055 (Assignment to DIMA or ARE Position Statement of Understanding): This form explains that you will receive base pay only for IDTs performed as a DIMA or ARE member. You are ineligible for travel and per diem pay for IDTs performed.

6. Take your finance packet with you when reporting for your first IDT. Your agency will witness the necessary documents. They will return the completed packet and your first DA Form 1380 to Cdr, U.S. Army Human Resources Command, ATTN: Reserve Pay Support Branch (AHRC-RMB-P), 1 Reserve Way, St. Louis, MO 63132-5200.

7. Reserve Pay Support Branch will return the forms to you for correction if errors exist which could delay the completion of the DJMS-RC processing and receipt of your pay. Enclose your home/work telephone numbers and a copy of your current promotion letter or order.

8. You must submit all of the IDTs you perform on a DA Form 1380 (Record of Individual Performance of Reserve Duty Training). IAW AR 14G145, Chapter 4, para 4-5(f), DA Form 1380 will be submitted within three days after IDTs are performed. DA Form 1380 may not be submitted prior to performing IDTs. The Reserve Pay Support Branch will process your DIMA or ARE IDT pay but must have a DD Form 577 (Signature Card) on file for those individuals authorized to sign your DA Form 1380 for IDTs.

9. The HRC-St. Louis Reserve Pay Support Branch is the point of contact for any pay related inquiry. You may reach them at commercial 314-592-0482 or DSN 892-0482.

FOR THE COMMANDER:

JAMES E. OTTO
COL, FI
Director, Plans

10 Encls
as

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE DATE

SIGNATURE DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE DATE

SIGNATURE DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME

GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME | SIGNATURE OF REPRESENTATIVE | TELEPHONE NUMBER | DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

PAYEE COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

Form W-4 (2004)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2004 expires February 16, 2005. See **Pub. 505,** Tax Withholding and Estimated Tax.

Note: *You cannot claim exemption from withholding if: **(a)** your income exceeds $800 and includes more than $250 of unearned income (e.g., interest and dividends) and **(b)** another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919,** How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using **Form 1040-ES,** Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2004. See Pub. 919, especially if your earnings exceed $125,000 (Single) or $175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less. . . B _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . E _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . F _____
(**Note:** *Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.*)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $52,000 ($77,000 if married), enter "2" for each eligible child.
- If your total income will be between $52,000 and $84,000 ($77,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children. G _____

H Add lines A through G and enter total here. **Note:** *This may be different from the number of exemptions you claim on your tax return.* ▶ H _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Your employer must send a copy of this form to the IRS if: (a) you claim more than 10 allowances or (b) you claim "Exempt" and your wages are normally more than $200 per week.**

OMB No. 1545-0010
2004

1 Type or print your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.*	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) 5

6 Additional amount, if any, you want withheld from each paycheck . . . . . 6 $

7 I claim exemption from withholding for 2004, and I certify that I meet **both** of the following conditions for exemption:
- Last year I had a right to a refund of **all** Federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** Federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ 7

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature
(Form is not valid unless you sign it.) ▶ Date ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

STATE OF LEGAL RESIDENCE CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Tax Reform Act of 1976, Public Law 94-455.

PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

ROUTINE USES: Information herein will be furnished State authorities and to Members of Congress.

MANDATORY OR VOLUNTARY DISCLOSURE: Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

NAME *(Last, first, middle initial)*	SOCIAL SECURITY NUMBER *(SSN)*

LEGAL RESIDENCE/DOMICILE *(City or county and State)*

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile. In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend upon legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that, to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

SIGNATURE	CURRENT MAILING ADDRESS *(Include ZIP Code)*	DATE

STATE INCOME TAX EXEMPTION TEST CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: 5 USC 5516, 5517, and EO 9397, November 1943.
PRINCIPAL PURPOSE: To enable the service concerned to terminate withholding of State income taxes applicable to your pay for the tax year specified. Social Security Number *(SSN)* will be used to provide positive identification.
ROUTINE USES: The information obtained will become part of the active duty pay system of records of the service concerned and may be disclosed to the routine users *(including State tax authorities)* of such system as described in the record system notices for such system.
DISCLOSURE: Disclosure is voluntary. Failure to complete this form will result in withholding of State income taxes from your pay. Disclosure of SSN is voluntary. However, to avoid erroneous application of your withholding exemption to the account of another member, this exemption certificate will not be processed without your SSN.

TYPE OR PRINT NAME *(Last, First, Middle Initial)*	SOCIAL SECURITY NUMBER
MILITARY ADDRESS *(Street Address, City, State, ZIP Code)*	TAX YEAR
	STATE OF LEGAL RESIDENCE
ADDRESS OF PLACE OF ABODE OUTSIDE YOUR STATE OF LEGAL RESIDENCE *(Street Address, City, State, ZIP Code)*	

I CERTIFY THAT I ANTICIPATE MEETING THE THREE CONDITIONS NECESSARY TO BE EXEMPT FROM WITHHOLDING FOR THE CALENDAR YEAR _____ . I ALSO DECLARE THAT I WILL IMMEDIATELY NOTIFY THE FINANCE OFFICER OF ANY CHANGES THAT AFFECT MY WITHHOLDING STATUS.

SIGNATURE OF APPLICANT	DATE *(YYMMDD)*

This form is currently applicable to the States of New Jersey, New York, and Oregon - AND is not to be used to change State of legal residence.

INSTRUCTIONS

The explanatory material below should help you determine if you qualify for exemption from State income tax withholding under this test. If you are unsure of your particular State law provisions for exemption from withholding, you should write your State taxing authority.

Residents of applicable states who enter military service and are assigned to duty outside those States do not change residence because of such assignments. They remain residents of those States for tax purposes unless they fulfill all three of the following conditions:

1. They maintain no place of abode in their State of legal residence during the taxable year,

2. They do maintain a place of abode outside that State for the entire taxable year, and

3. They spend no more than 30 days in that State during the taxable year.

The following are not considered places of abode under condition 2:

a. An abode maintained while on temporary duty or while attending a specialized training school away from your permanent duty station. A member who is otherwise considered to maintain a place of abode outside his or her State of legal residence does not lose the place of abode solely because of performance of duty at another location if such place of abode is still maintained by the member.

b. Quarters occupied by a barracks, on shipboard, or in bachelor officer quarters at your permanent duty station. This restriction applies only to New Jersey and New York residents. If your status under condition 2 is unclear, you should consult your legal assistance officer before completing the form.

If the spouse and family of a married individual in military service continue to reside in the State of legal residence, their abode is considered to be an abode maintained by the service member. Condition 1 would therefore not be met.

Effective date of exemption election. Withholding of State income tax will stop the month after the month in which the certificate is filed. Retroactive adjustments will not be made.

NATIVE AMERICAN STATE INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 5516, 5517, and EO 9397.

PRINCIPAL PURPOSE(S): To enable a Native American service member to stop State income taxes withholding from military compensation.

ROUTINE USE(S): The information obtained will become part of the active duty pay system of records of the service concerned and may be disclosed to routine users of these records (including State tax authorities) as disclosed in its record system notice.

DISCLOSURE: Disclosure is voluntary. Failure to complete this form will result in withholding of State income taxes from your pay. Disclosure of SSN is voluntary. However, to avoid erroneous application of your withholding exemption to the account of another member, this exemption certificate will not be processed without your SSN.

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER

3. MILITARY ADDRESS *(Unit, Street, City, State, ZIP Code)*

4. CURRENT MAILING ADDRESS *(Street, City, State, ZIP Code)*

5. NAME OF FEDERALLY RECOGNIZED TRIBE THAT YOU ARE A MEMBER OF

6. NAME OF FEDERALLY RECOGNIZED TRIBAL RESERVATION OR INDIAN COUNTRY THAT YOU CLAIM AS YOUR DOMICILE *(Include the name of the State the reservation is located within)*

7. I CERTIFY THAT I ANTICIPATE MEETING THE TWO CONDITIONS NECESSARY TO BE EXEMPT FROM WITHHOLDING FOR THE CALENDAR YEAR _____ . I ALSO DECLARE THAT I WILL IMMEDIATELY NOTIFY THE FINANCE OFFICER OF ANY CHANGES THAT AFFECT MY WITHHOLDING STATUS.

8. SIGNATURE OF APPLICANT	9. DATE *(YYYYMMDD)*

INSTRUCTIONS

Completing this certificate allows you to claim exemption from State income tax withholding on your military compensation if you satisfy the following tests:

1. You claim as your State of legal residency/domicile a federally recognized tribal reservation or Indian Country.

2. You are an enrolled member of that federally recognized Native American tribe.

If you satisfy these conditions, the Soldiers' and Sailors' Civil Relief Act provides that your tax home remains on the reservation/in Indian country. Consequently, you may stop State income tax withholding on your military compensation.

If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG representative) for advice prior to completing this form.

Effective date of exemption election. Withholding of State income tax will stop the month after the month in which you file this certificate. DFAS cannot make retroactive adjustments.

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSES: This form is used to designate beneficiaries for certain benefits in the event of the servicemember's death. It is a guide for the disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the servicemember desires to be notified in case of emergency or death. The purpose of soliciting the SSN is to provide positive identification.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide personal identifier information may delay notification of the servicemember's status or may handicap processing of benefits to designated beneficiaries.

INSTRUCTIONS TO SERVICEMEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty, and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to bene- ficiaries to receive certain death payments, and to show changes in your family or other dependents listed; for example, as a result of marriage, civil court action, death, or address change. Regarding your designation in Item 11, "Allotment if Missing" (if used by your Service), please read the following statement carefully, and sign on the line provided:

I fully understand that, if I am captured, missing, or interned, my designation of allotments to dependents from my pay and allowances serves only as a guide to the Secretary of my Service. The Secretary may alter my designated allotment in the best interests of myself, my dependents, or the United States Government.

_____

(Signature of Servicemember)

1. NAME *(Last, First, Middle)*	2a. SSN	b. INITIAL *(To indicate valid SSN)*	3a. SERVICE	b. REPORTING UNIT CODE DUTY STATION
4a. SPOUSE NAME	b. ADDRESS *(Include ZIP Code)*			
5. CHILDREN a. NAME	b. RELATIONSHIP	c. DATE OF BIRTH *(YYYYMMDD)*	d. ADDRESS *(Include ZIP Code)*	
6a. FATHER NAME	b. ADDRESS *(Include ZIP Code)*			
7a. MOTHER NAME	b. ADDRESS *(Include ZIP Code)*			
8a. DO NOT NOTIFY DUE TO ILL HEALTH	b. NOTIFY INSTEAD			

9a. BENEFICIARY(IES) FOR DEATH GRATUITY *(If no surviving spouse or child)*	b. ADDRESS *(Include ZIP Code)*	c. PERCENTAGE
10a. BENEFICIARY(IES) FOR UNPAID PAY/ ALLOWANCES	**b. ADDRESS** *(Include ZIP Code)*	**c. PERCENTAGE**

11. ALLOTMENT DESIGNEE/PERCENTAGE IF MISSING *(Subject to Secretarial determination)*

12. INSURANCE *(SGLI and other Insurance Companies/Policy Numbers)*	a. SGLI *(Optional Service Use)* ☐ MAXIMUM ☐ NO ☐ OTHER *(Amount)* _____	b. INSURANCE COMPANIES/POLICY NUMBERS

13. CONTINUATION/REMARKS

14. SIGNATURE OF SERVICEMEMBER *(Include rank, rate, or grade)*	15. SIGNATURE OF WITNESS *(Include rank, rate, or grade)*	16. DATE SIGNED *(YYYYMMDD)*

Request for Family Coverage

Part I - To Be Completed By Member

1. First Name - Middle Name - Last Name - Suffix	2. Social Security Number	3. Branch of Service

4. Amount of SGLI Now In Force	5. Amount of Coverage Desired for Spouse

I understand that if I fail to furnish satisfactory evidence of my spouse's insurability, the fact that withholdings have been made from my pay for the insurance being requested will not create any liability for insurance, and that I will be entitled to appropriate credit for such withholdings.

6. Signature of Servicemember	7. Date (dd-mmm-yyyy e.g. 12-NOV-2001)

Part II – To Be Completed By Spouse

8. First Name - Middle Name - Last Name - Suffix	9. Social Security Number	10. Date of Birth (dd-mmm-yyyy e.g. 12-NOV-2001)

11. Weight (lbs)	12. Height (ft & ins)	13. Gender ☐ Male ☐ Female

	Yes	No		Yes	No
14. Have you ever been diagnosed as having a disease or disorder of the immune system?			C. Nervous disorder?		
15. Have you had or been treated for known indications of :			D. Diabetes?		
A. A heart condition?			E. Cancer or tumors?		
B. High blood pressure?			16. Do you have any known physical or mental impairments, deformities, or ill health not covered above?		

17. If your answer to any part of items 12 through 14 is yes, please refer to item number and give dates, duration and other details. (If more space is needed, attach a separate sheet)

The answers I have given are for securing approval of this request for insurance and I certify that they are true and correct to the best of my knowledge and belief. I understand that the insurance being requested requires approval of insurability by the Office of Servicemembers' Group Life Insurance. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

18. Signature of Spouse	19. Mailing Address	20. Date (dd-mmm-yyyy e.g. 12-NOV-2001)

Part III – To Be Completed By Member's Commanding Officer (or designee)

I certify that the signature in Part I above is that of the member named and according to the records of this department, this member is eligible to apply for the amount of family coverage requested above.

21. Name of Commanding Officer or designee (please print)	22. Organization and Mailing Address	23. Rank, Title or Grade
24. Signature of Commanding Officer or designee		25. Date *(dd-mmm-yyyy e.g. 12-NOV-2001)*

For OSGLI Use Only

☐ Approve ☐ Disapprove	Signature of OSGLI Representative	Date (dd-mmm-yyyy e.g. 12-NOV-2001)

To be retained in member's official personnel file

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)
- ☐ Name or update your beneficiary
- ☐ Reduce the amount of your insurance coverage
- ☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name	First name	Middle name	Rank, title or grade	Social Security Number

Branch of Service (Do not abbreviate)	Current Duty Location

Amount of Insurance

By law, you are automatically insured for $250,000. ***If you want $250,000 of insurance***, skip to *Beneficiary(ies) and Payment Options*. ***If you want less than $250,000*** of insurance, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of $10,000. ***If you do not want any insurance****, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage under the SGLI program.

☐ I want coverage in the amount of $_____ Your initials_____

☐ _____

(Write "I do not want Insurance at this time.")

Note: Reduced or refused insurance can *only* be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of VGLI you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, $ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1.				
2.				
3.				
4.				
☐ Additional Principals on page 5 (check if applicable)				
Contingent				
1.				
2.				
3.				
4.				
☐ Additional Contingents on page 5 (check if applicable)				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- ***This form cancels any prior beneficiary or payment instructions.***
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than $250,000.

SIGN HERE IN INK ➤ _____ Date: _____

(Your signature. Do not print.)

Do not write in space below. For official use only.

WITNESSED AND RECEIVED BY:	RANK, TITLE OR GRADE	ORGANIZATION	DATE RECEIVED

Please read the instructions before completing this form.

Family Coverage Election

Servicemember's Information

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Date of Birth	Social Security Number

Branch of Service (Do not abbreviate)	Rank, title or grade
Choose Branch	

Amount of Insurance

Family Coverage for Dependent Child(ren). By law, if you are insured under SGLI, each of your dependent children (see page 3 for a definition of dependent children for SGLI purposes) is automatically insured for $10,000.

Family Coverage for Spouse. By law, if you are insured under SGLI, **your spouse is automatically insured for $100,000 or the amount of your SGLI coverage**, whichever is less. ***If you want less than the automatic amount of coverage for your spouse***, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of $10,000. ***If you do not want any coverage for your spouse****, check the appropriate block below and write (in your own handwriting), "I do not want coverage for my spouse at this time."

☐ I want coverage in the amount of $_____

☐ _____

(Write "I do not want coverage for my spouse at this time.")

****Note:*** Reduced or refused family coverage can *only* be restored by completing form SGLV 8285A with proof of good health and compliance with other requirements. It will also affect the amount of insurance your spouse can convert to when Family Coverage expires.

Spouse's Information

(To be completed by member. It is not necessary to complete this section if you're declining coverage.)

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number

Date of Birth (dd-mmm-yyyy e.g. 24-AUG-1965)	

Premiums for Spousal Coverage

Spouse's age:	*Monthly rate per $10,000*	*Monthly cost for $100,000 coverage*
Under 35	$.60	$6.00
35-39	$.75	$7.50
40-44	$1.00	$10.00
45-49	$1.90	$19.00
50-54	$2.80	$28.00
55-59	$4.20	$42.00
60 & older	$5.40	$54.00

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form and certify that the information I have provided is correct.

SIGNATURE OF SERVICEMEMBER ➤ _____ Date: _____
(dd-mmm-yyyy e.g. 01-NOV-2001)

Do not write in space below. For official use only.

Witnessed and received by: (please print)	Rank, title or grade	Organization	Date Received (dd-mmm-yyyy e.g. 01-NOV-2001)

TERMINATION STATEMENT

for

SERVICEMEMBER'S GROUP LIFE INSURANCE (SGLI)

If you currently have SGLI coverage under other than a Drilling Individual Mobilization Augmentation (DIMA) or Army Reserve Element (ARE) status, termination is required in order to prevent duplicate billing to you. Signing the below statement will terminate other SGLI coverage which you may have. The Defense Finance and Accounting System (DFAS) will automatically deduct the SGLI premiums from your Inactive Duty Training pay. In order to have SGLI coverage under the DIMA or ARE Program, you must complete and return the forms in the enclosed packet.

I request to be terminated from my current SGLI coverage because I am now assigned in the DIMA or ARE program. I understand DFAS will automatically deduct the SGLI payments from my IDT pay.

_____

DATE

_____

PRINTED NAME

_____

SSN

_____

SIGNATURE

Assignment to DIMA or ARE Position

Statement of Understanding

I understand that upon my assignment to a Drilling Individual Mobilization Augmentation (DIMA) or Army Reserve Element (ARE) position, I am not entitled to travel or per diem for Inactive Duty Training (IDT) performed. I will receive base pay only.

_____
DATE

_____
PRINTED NAME

_____
SSN

_____
SIGNATURE

AHRC Form 4055, Dec 03 (Prior editions are obsolete.)